FY 2017 IPPS Final Rule Contains Good and Bad

The Centers for Medicare & Medicaid Services (CMS) final rule for the fiscal year (FY) 2017 hospital inpatient prospective payment system, issued last week, appears to be a mixed bag for hospitals. On the up side, CMS reversed the effects of the 0.2% payment reduction that was part of the original “two-midnight” policy and chose to pause the incorporation of Worksheet S-10 uncompensated care data in order to improve its accuracy and consistency in determining the cost of treating uninsured patients. However, the rule also finalizes an unjustified cut to reimbursement rates for hospital services by incorporating a 1.5% cut to fulfill the requirement of the American Taxpayer Relief Act of 2012 (ATRA) that meant to recoup what CMS claims is the effect of documentation and coding changes from FYs 2010-2012.

The ATRA-related cuts are extremely disappointing, since they nearly double the amount which Congress specified in the ATRA legislation, as well as in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The American Hospital Association (AHA) will urge the agency to restore the full amount allowed by law to the standardized amount in FY 2018.

In addition, while CMS reduced its proposed requirements on reporting electronic clinical quality measures (eCQMs), much more work needs to be done to ensure that the measures are valid and reliable before broad-scale implementation. Against AHA’s recommendation, CMS will expand, beginning with the FY 2019 Inpatient Quality Reporting (IQR) Program, the requirement to report electronic clinical quality measures. Starting in CY 2017, CMS will require that hospitals select and submit four quarters of data on eight of 15 eCQMs available in the IQR. CMS also will begin to validate eCQM data reported during CY 2018, which will affect payment in FY 2020.

Overall, the rule will increase Medicare hospital inpatient rates by 0.95% compared to FY 2016, after accounting for inflation and the adjustments required by law. In another move, CMS also implemented the Notice of Observation Treatment and Implication for Care Eligibility Act, which requires hospitals and critical access hospitals to provide a written and oral notification to Medicare beneficiaries receiving observation services as outpatients for more than 24 hours. In doing so, CMS makes a number of changes recommended by AHA, including providing hospitals with more than four months to fully implement the use of the standardized Medicare Outpatient Observation Notification.


Arkansas Practices Eligible to Apply for Medicare CPC+

Arkansas is included among 14 regions of the country where eligible Medicaid practices may apply through September 15 to participate in Medicare’s Comprehensive Primary Care Plus (CPC+) model, a five-year medical home model beginning in January. CMS named the regions August 1.
The multi-payer model, announced in April, will build on the current Comprehensive Primary Care initiative to help practices support patients with serious or chronic diseases. CMS has provisionally selected to partner with 57 payer organizations in the 14 regions, including commercial payers and state Medicaid agencies on the project.

The goal of CPC+ is to improve the quality of care patients receive, improve patients’ health, and spend healthcare dollars more wisely. Practices in both tracks will make changes in the way they deliver care, centered on key comprehensive primary care functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health.

To support the delivery of comprehensive primary care, CPC+ includes three payment elements:

1. **Care Management Fee (CMF):** Both tracks provide a non-visit based CMF paid PBPM. The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific population. The Medicare FFS CMFs will be paid to the practice on a quarterly basis.

2. **Performance-based incentive payment:** CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.

3. **Payment under the Medicare Physician Fee Schedule:** Track 1 continues to bill and receive payment from Medicare FFS as usual. Track 2 practices also continue to bill as usual, but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis absent a claim. Given our expectations that Track 2 practices will increase the comprehensiveness of care delivered, the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

CMS will be conducting a series of CPC+ Practice Open Door Forum sessions during August. A calendar of those sessions is available on the Arkansas Hospital Association website at [http://www.arkhospitals.org/Misc.%20Files/CPC+PracticeEventsCalendar.pdf](http://www.arkhospitals.org/Misc.%20Files/CPC+PracticeEventsCalendar.pdf). Please click on the event link and enter your information. You will receive an email with details for attending the webinar. For reasonable accommodation, please contact CPCplus@cms.hhs.gov. To learn more about the CPC+ model, click on [https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus/](https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus/).

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**AHA Hosting August 10 Virtual Advocacy Day**

The American Hospital Association (AHA) will host a special members-only virtual advocacy day on Wednesday, August 10 at 1:00 p.m. CT focused on the site-neutral payment provisions included in last month’s outpatient prospective payment system (OPPS) proposed rule. The rule proposes to implement the site-neutral provisions of the Bipartisan Budget Act of 2015, which requires that, with the exception of dedicated emergency departments, items and services furnished in new off-campus provider-based departments (those that began billing under the OPPS on or after November 2, 2015) will no longer be paid under the OPPS. Instead these services will be paid under other “applicable payment systems” under Medicare Part B beginning January 1, 2017.

In this webcast, AHA executive vice president of government relations and public policy Tom Nickels and vice president of payment policy Joanna Hiatt Kim will highlight the AHA’s concerns with this proposal. They also will outline the steps hospital leaders can take – both with the Centers for Medicare & Medicaid Services and their federal legislators – to advocate for changes to these
misguided policies so that hospitals can continue to provide the highest quality healthcare to their communities.

Please note that registration is required for all participants. To register/log in, please click on http://mp125118.cdn.mediaplatform.com/125118/wc/mp/4000/5592/29477/64538/Lobby/default.htm. If you have questions about the webcast, call (800) 424-4301, or email support@windrosemmedia.com if you have any additional technical questions.

Guidance Limits Medicaid MCO Pass-Through Pay

An informational bulletin issued last week by CMS addresses questions regarding the ability of states to increase or add pass-through payments for healthcare providers under Medicaid managed care contracts and capitation rates. A May final rule updating Medicaid managed care requirements provides for a 10-year phase-out of these payments.

The bulletin notes, “Adding new or increased pass-through payments for hospitals, physicians and nursing facilities, beyond what was included as of July 5, 2016, into Medicaid managed care contracts would exacerbate a problematic practice that is inconsistent with statutory and regulatory requirements, complicates the transition of these pass-through payments to permissible provider payment models, and reduces managed care plans’ ability to effectively use valued-based purchasing strategies and implement provider-based quality initiatives.”

CMS intends to further address this policy in future rulemaking, linking pass-through payments through the transition period to amounts in place at the time the Medicaid managed care rule was effective on July 5, 2016. CMS said it will use its contract and rate certification approval processes to closely monitor pass-through payments.


The AHA Calendar

August 2016

9 Strategic Planning for Healthcare Boards: The Value of Peer Organization Networks – Webinar TX080916
9 Chargemasters: Proper Supply & Device Categorization – Webinar T3060
11 Mutual Interest Conflict Resolution – Webinar T3061
11-12 AHA Board Retreat, Red Apple Inn & Country Club, Heber Springs
15 careLearning PassPort Program Common Orientation for Clinical Rotation Webinar
17-19 14th Annual Mid-South CAH Conference, Omni Nashville Hotel
18 Practical Preparedness for Workplace Violence – Webinar IA0818
24 Make the Most of AHA’s Salary Survey Webinar
25 Basic/Intermediate Medical Terminology, AHA Classroom, Little Rock
31 careLearning PassPort Program Common Orientation for Clinical Rotation Webinar

Information on all AHA educational programs and activities is available at http://www.arkhospitals.org/event.
Final Thoughts by Paul Cunningham

If you are interested in both healthcare and history, then you might want to note the anniversary of a rather inauspicious healthcare-related event which occurred nineteen years ago last Friday. It was monumental at the time and left a lingering impression on healthcare and hospitals. On August 5, 1997, President Bill Clinton signed the Balanced Budget Act (BBA) of 1997.

Congress originally passed the law with the intent of reducing overall federal spending by roughly $130 billion for the period 1998-2002 in order to balance the federal budget. The financial whiz kids at the Congressional Budget Office (CBO), Office of Management and Budget, and Health Care Financing Administration (now CMS) were projecting that the act would cut future Medicare spending $116 billion. Despite warnings of hospital leaders, who knew better, they also said that hospitals would absorb only about $35 billion of the total.

The law worked. In fact, much better than anticipated, but it also unleashed a harsh reality upon the nation’s hospitals that most government leaders would not begin to recognize until 1999. According to a CBO report released that year, hospital losses were tracking to hit $72 billion for the period 1998 to 2002, double the original projection, and approach $120 billion through 2004. Data from the Medicare Payment Advisory Commission (MedPAC) later confirmed that hospitals’ overall Medicare margins decreased from 10.3% in 1996 to 1.7% in 2002. At the same time, private payer payments also decreased, adding to hospitals’ financial stress.

As the dramatic reductions in revenues associated with the BBA’s Medicare provisions took hold, concerns were growing about the unintended consequences on hospitals, skilled nursing facilities and home health services, as well as graduate medical education.

Ultimately, Congress and the President later agreed to restore about $20 billion of the hospital-related BBA reductions through subsequent laws in 1999 and 2000. Even so, a study completed later for the American Hospital Association estimated the act’s final net financial impact on the nation’s hospitals at somewhere in the vicinity of $100 billion. In its wake, the law also left a trail of closed hospitals, convincing MedPAC finally to acknowledge the resulting financial stress and hardships which it had created.

A hidden BBA repercussion was the threat it presented to patient care. A study published in the June 2006 issue of Health Services Research looked into hospitals’ warnings that the draconian Medicare cuts would lead to decreased service provision and lower quality of care. The conclusion was just what you’d expect: As cuts in reimbursement continued, there was an ongoing challenge for hospitals to continue to provide high-quality care using fewer resources. Fortunately, the funding restored in 1999 and 2000 helped keep that situation from becoming too widespread.

In hindsight, the BBA might seem like small potatoes when compared with the Affordable Care Act (ACA), which came on the scene 13 years later. Whereas the BBA’s original price tag for hospitals was estimated at $35 billion over five years, the ACA immediately threatened $155 over ten years, but also included revenue offsets in the form of more insured people. However, the ACA did not forewarn of other sizeable Medicare cuts to come in 2011 and 2012, which, when quilted together, will push the price tag for U.S. hospitals well beyond $350 billion through 2024 and those in Arkansas to something north of $2.5 billion. More cuts could well be in store.

Of course, with the ACA et al, Congress did avoid the potential repercussions on quality of care that stemmed from the BBA. This time they decided to cut payments while announcing that advancement in quality of care was part and parcel to the move toward a value-based healthcare system and there have been positive steps on patient outcomes as a result. But, it is up to Congress to guard against taking another road to a balanced budget in the future that, like the BBA, jeopardizes the delicate healthcare safety net which hospitals provide for their communities.

George Santayana, the Spanish philosopher and writer, not the leader of Mexican troops at the Battle of the Alamo – that was General Antonio López de Santa Anna – once observed, “Those who do not remember the past are condemned to repeat it.” The gist is that if you don’t learn from your mistakes, you’ll do the same dumb thing again and again. We can only hope that members of Congress understand as they continue to tinker with Medicare and Medicaid policies to which so many hospitals, especially of the small and rural variety, are extremely sensitive.